DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 9 8 — 0 0 9

2. STATE: MA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)
Title XIX

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
October 1, 1998

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:
42 CFR 447.250-299

7. FEDERAL BUDGET IMPACT:
a. FFY 1999 $11,380
b. FFY 2000 $11,596

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19-A(2b)

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Same

10. SUBJECT OF AMENDMENT:
Non State owned Psychiatric Hospital Payment Methods

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
Not required under 42 CFR 430.12(b)(2)(i)

12. SIGNATURE OF STATE AGENCY OFFICIAL:
Bruce M. Bullen per CS

13. TYPED NAME:
Bruce M. Bullen

14. TITLE:
Commissioner

15. DATE SUBMITTED:
December 30, 1998

16. RETURN TO:
Bridget Landers
Coordinator for the State Plan
Division of Medical Assistance
600 Washington Street
Boston, MA 02111

DEC 31 COSTAR

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
December 31 1998

18. DATE APPROVED:

PLAN APPROVED ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
October 1, 1998

20. TYPED NAME:
Ronald E. Preston

21. TITLE:
Regional Program Director

22. REMARKS:

OFFICIAL

FORM HCFA-179 (07-92)

Instructions on Back

State Plan under Title XIX of the Social Security Act
Massachusetts Medical Assistance Program

Methods Used to Determine Rates of Payment
for Non-State-Owned Psychiatric Hospital Services

I. General Description of Payment Methodology

The following sections describe the methods and standards utilized by the Division of Medical Assistance ("Division") to establish rates of payment by contract, to be effective October 1, 1998 (Rate Year (RY) 1999), for services rendered by non-State-owned Psychiatric Hospitals to patients entitled to medical assistance under M.G.L. c. 118E, §1 *et seq.* These rates of payment do not apply to Recipients who are enrolled in the Division's Mental Health/Substance Abuse Program.

(1) The former charge-based method of reimbursing inpatient services on a per-service basis is no longer employed. The new method establishes a comprehensive Inpatient Per Diem Rate that covers both routine services and ancillary services provided to inpatients. The inpatient per diem rate was derived from two RY 1999 rates: a statewide per diem rate and a hospital-specific per diem rate.

(2) For those non-State-owned Psychiatric Hospitals without claims or with fewer than 30 claims paid through the Massachusetts Medicaid program during RY 1996-5/98, the statewide rate shall be immediately and fully applicable, beginning in RY 1999. For those non-State-owned Psychiatric Hospitals with 30 or more claims paid through the Massachusetts Medicaid program during RY 1996-5/98, a 50-50 blend of the hospital-specific rate and statewide rate will be applied in RY 1999. It is anticipated that beginning in RY 2000, all non-State-owned Psychiatric Hospitals will be paid at the statewide per diem rate, as annually updated by the specified inflation factor.

(3) An all-inclusive Administrative Day Per Diem Rate (AD Rate) is established for each Administrative Day. The AD Rate is comprised of a base per diem payment and ancillary add-on. The base per diem payment is the average Massachusetts Medicaid nursing home rate in State Fiscal Year 1995 for acuity categories H to L. This base rate is $75.83. The ancillary add-on ratio of 0.2969 was derived from acute hospital payment methods for RY 1997, which include payments for psychiatric units in acute non-State-owned Psychiatric Hospitals. The resulting AD rate (base and ancillary) was then updated by an inflation adjustment to derive the AD rate for RY 1999.

II. Definitions

Administrative Day (AD). A day of inpatient hospitalization on which a Recipient's care needs can be met in a less-intensive setting than a Psychiatric Hospital, and on which the Recipient is clinically ready for discharge, but an appropriate institutional or non-institutional setting is not readily available.

Administrative Day Per Diem Rate (AD Rate). An all-inclusive daily rate of payment paid to Non-State-owned Psychiatric Hospitals for Administrative Days.

Charge. The amount that is billed or charged by a hospital for each specific service within a revenue center.

Department of Mental Health (DMH). An agency of the Commonwealth of Massachusetts established under M.G.L. c. 19, §1 ***et seq***.

Department of Public Health (DPH). An agency of the Commonwealth of Massachusetts established under M.G.L. c. 17, §1.

Division of Health Care Finance and Policy (DHCFP). An agency of the Commonwealth of Massachusetts, Executive Office of Health and Human Services established under M.G.L. c. 118G.

Division of Medical Assistance (Division) An agency of the Commonwealth of Massachusetts established under M.G.L. c. 118E.

HURM Manual. The Commonwealth of Massachusetts Hospital Uniform Reporting Manual promulgated by DHCFP under 114.1 CMR 4.00.

Inpatient Day. The standard unit of measure, according to the HURM Manual, to report care of patients admitted to a hospital including the day of admission, but not the day of discharge. If both occur on the same day, the day is considered a day of admission and counts as one inpatient day.

Inpatient Per Diem Rate. An all-inclusive daily rate of payment for any and all Inpatient Services provided to a Recipient by a non-State-owned Psychiatric Hospital.

Inpatient Service. Psychiatric care and treatment, provided under the direction of a psychiatrist, which is provided to an individual admitted as an inpatient to a Psychiatric

Hospital.
Medicaid Program (Medicaid). The medical assistance benefit plans administered by the Division pursuant to M.G.L. c. 118E, §1 *et seq.* and 42 U.S.C. §1396 *et seq.* (Medicaid).

Mental Health/Substance Abuse Program (MH/SA Program). A managed care program for the provision of mental health and substance abuse services to Recipients enrolled in the program.

Non-acute Hospital. A hospital that is defined and licensed under M.G.L. c. 111, s. 51, with less than a majority of medical surgical, pediatric, maternity and obstetric beds, or any psychiatric facility licensed under M.G.L. c. 19, s. 29.

Psychiatric Hospital. Any psychiatric facility licensed under M.G.L. c. 19, s.29.

Rate Year (RY). The period beginning October 1 and ending September 30. RY 1999 will begin on October 1, 1998 and end on September 30, 1999.

Recipient. A person determined by the Division to be eligible for medical assistance under the Medicaid Program.

State-Owned Non-Acute Hospital. A hospital that is operated by the Massachusetts Department of Public Health (DPH) with less than a majority of medical surgical, pediatric, maternity and obstetric beds, or any psychiatric facility operated by the Department of Mental Health.

III. Medicaid Reimbursement Methodology for Non-State-owned Psychiatric Hospitals

III.A. Inpatient Per Diem Rate

The Inpatient Per Diem Rate is an all-inclusive daily rate paid for any and all inpatient care and services provided by a non-State-Owned Psychiatric Hospital to a Medicaid Recipient, with the exception of any and all Administrative Days (see Section III.B.). The Inpatient Per Diem Rate covers room and board, routine nursing services, ancillary services, psychological testing, and assessments, overhead, and other services as is the customary practice among similar providers.

(1) Data Sources.

(a) Base Period. The RY 1998 Inpatient Per Diem Rate was calculated using payments and Inpatient Days reported on Medicaid Psychiatric hospital claims

data during the period RY 1996 through RY 1998 (up to May 98). This is the most recent claims data available for calculation of RY 1999 rates. The base period was specified as Medicaid payments made during this same period, RY 1996 through May 1998. Claims data and Inpatient Days for the Division's MH/SA program are not included.

(b) Update Factor. The Base Period amounts are adjusted for inflation from the Base Period through Rate year 1999 using a composite index called the SPAD inflation factor. This adjustment factor is a blend of HCFA market basket and the Massachusetts Consumer Price Index (CPI). The RY 1999 SPAD inflation factor is 1.90 per cent.

(c) Efficiency Standard. Under the previous Payment On Account (PAF) payment system, there were no incentives for efficiency since Medicaid paid a percentage of non-State-owned Psychiatric Hospital charges, and these charges were deregulated under state law. A 95 percent adjustment factor to the base statewide rate is used as an incentive for efficiency. This is the same efficiency adjustment factor that has been used by Medicare in setting payment for its managed care enrollees under the adjusted average per capita cost (AAPCC) payment system.

(2) Determination of RY 1999 Per Diem Rates. As described below, two RY 1999 rates are calculated: a statewide rate and a hospital-specific rate. These rates are used to transition all non-State-owned Psychiatric Hospitals to the statewide rate over a two-year period, beginning in RY 1999.. For both rates, the calculation begins with generating an initial rate for the period RY 1996 through RY 1998 (up to May 1998). All amounts are then annualized to RY 1998 dollars and then updated by the Medicaid SPAD inflation factor to generate RY 1999 rates.

(a) RY 1999 Statewide rate. The Division calculated the RY 1999 statewide per diem rate by taking a weighted average of payments per day reported on claims data for all non-State-owned Psychiatric Hospitals participating in the Medicaid program at any time during the period, RY 1996 through RY 1998 (up to May 1998). The weights were based on the proportion of Inpatient Days each hospital provided under the Medicaid program during this same period. As an incentive for improved efficiency, the 95% Efficiency Standard was applied to the initial statewide rate to yield the statewide per diem rate for RY 1998. RY 1998 figures were then updated to RY 1999 by multiplying by 1.90 percent (SPAD inflation factor for RY 1999).

(b) RY 1999 Hospital-specific rate. The Division calculated the RY 1999 hospital-specific per diem rate by averaging total payments and total Inpatient Days for each non-State-owned Psychiatric Hospital over the period: RY 1996 through RY 1998 (up to May 1998), as reported on the claims data for the Medicaid Psychiatric Hospital program. RY 1998 figures were updated to RY 1999 by multiplying by 1.90 percent (SPAD inflation factor for RY 1999).

(c) Transition to Statewide Per Diem Rate by RY 2000. For those non-State-owned Psychiatric Hospitals without claims or with fewer than 30 claims paid through the Massachusetts Medicaid program during RY 1996-5/98, the statewide rate shall be immediately and fully applicable, beginning in RY 1999. For those non-State-owned Psychiatric Hospitals with 30 or more claims paid through the Massachusetts Medicaid program during RY 1996-5/98, a 50-50 blend of the hospital-specific rate and statewide rate will be applied in RY 1999. It is anticipated that beginning in RY 2000, all non-State-owned Psychiatric Hospitals will be paid at the statewide per diem rate, as annually updated by the specified inflation factor.

III.B. Determination of Rate for Administrative Day Patients

A Non-State-owned Psychiatric Hospital will be paid for Administrative Days using an Administrative Day Per Diem Rate (AD Rate). The AD Rate is an all-inclusive daily rate paid for each Administrative Day. The AD Rate is based on the Medicaid acute inpatient hospital administrative day rate, and is comprised of a base per diem payment and ancillary add-on. The base per diem payment is the average Medicaid nursing home rate in State Fiscal Year 1995 for acuity categories H to L. This base rate is $75.83. The Ancillary add-on ratio 0.2969 was derived from the RY 1997 acute hospital ancillary payments, which covers psychiatric units in acute Hospitals. The resulting AD rate (base and ancillary) was then updated for inflation using the update factors 3.16% for RY 1996, 2.38% for RY 1997, 2.14% for RY 1998, and 1.9% for RY 1999. The resulting AD rate for RY 1999 is $135.75.

IV. Determination of Federally Mandated Disproportionate Share Adjustments

The Medicaid program will assist hospitals which carry a disproportionate financial burden of caring for the uninsured and low income persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid will make an additional payment adjustment to hospitals which qualify for such an adjustment. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating these adjustments are described in Sections V and VI below.

(1) To qualify for any type of disproportionate share payment adjustment, a hospital must have a Medicaid inpatient utilization rate (calculated by dividing Medicaid patient days by total patient days) of not less than 1%.

(2) The total of all disproportionate share payments awarded to a particular hospital under Section V below shall not exceed the costs incurred during the year of furnishing hospital services to individuals who either are eligible for Medicaid or have no health insurance or source of third party coverage, less payments by Medicaid and by uninsured patients.

V. Federally Mandated Disproportionate Share Adjustments

(1) Data Sources. The Division shall determine for each fiscal year a federally mandated Medicaid disproportionate share adjustment for all eligible hospitals, using the data and methodology described below. The prior year DHCFP-403 report is used to determine Medicaid days, total days, Medicaid inpatient net revenues, total inpatient net revenues, total inpatient charges and free care charge-offs. If said DHCFP-403 report is not available, the Division shall use the most recent available prior year DHCFP-403 report to estimate these variables.

(2) Determination of Eligibility Under the Medicaid Utilization Method. The Division shall calculate a threshold Medicaid inpatient utilization rate to be used as a standard for determining the eligibility of all Non-acute Hospitals for the federally mandated disproportionate share adjustment. The Division shall determine such threshold as follows:

(a) First, calculate the statewide weighted average Medicaid inpatient utilization rate by dividing the sum of Medicaid days for all Non-acute Hospitals in the state by the sum of total inpatient days for all Non-acute Hospitals in the state.

(b) Second, calculate the statewide weighted standard deviation for Medicaid inpatient utilization statistics.

(c) Third, add the statewide weighted standard deviation for Medicaid inpatient utilization to the statewide weighted average Medicaid inpatient utilization rate. The sum of these two numbers is the threshold Medicaid inpatient utilization rate.

(d) The Division shall then calculate each hospital's Medicaid inpatient utilization rate by dividing each hospital's Medicaid inpatient days by its total inpatient days. If this hospital-specific Medicaid inpatient utilization rate equals or exceeds the threshold Medicaid inpatient utilization rate calculated pursuant to Section V (2)(c), then the hospital is eligible for the federally-mandated Medicaid disproportionate share adjustment under the Medicaid utilization method.

(3) Determination of Eligibility Under the Low-Income Utilization Rate Method.

The Division shall then calculate each hospital's low-income utilization rate. The Division shall make such determination as follows:

(a) First, calculate the Medicaid and subsidy share of net revenues by dividing the sum of Medicaid net revenues and state and local government subsidies by the sum of total net revenues and state and local government subsidies.

(b) Second, calculate the free care percentage of total inpatient charges by dividing the inpatient share of audited free care charge-offs by total inpatient charges.

(c) Third, compute the low-income utilization rate by adding the Medicaid and subsidy share of net revenues calculated pursuant to Section V (3)(a) to the free care percentage of total inpatient charges calculated pursuant to Section V (3)(b). If the low-income utilization rate exceeds 25%, the hospital is eligible for the federally-mandated Medicaid disproportionate share adjustment under the low-income utilization rate method.

(4) Determination of Payment. The payment under the federally mandated disproportionate share adjustment is calculated as follows:

(a) For each hospital determined eligible for the federally-mandated disproportionate share adjustment under the Medicaid utilization method established in Section V (2), the Division shall divide the hospital's Medicaid utilization rate calculated pursuant to Section V (2)(d) by the threshold Medicaid utilization rate calculated pursuant to Section V (2)(c). The ratio resulting from such division is the federally mandated disproportionate share ratio.

(b) For each hospital determined eligible for the federally mandated disproportionate share adjustment under the low-income utilization rate method, but not found to be eligible for the federally mandated Medicaid disproportionate share adjustment under the Medicaid utilization method, the Division shall set the hospital's federally mandated disproportionate share ratio equal to one.

(c) The Division shall then determine, for the group of all eligible hospitals, the sum of federally mandated disproportionate share ratios calculated pursuant to Section V (4)(a) and Section V (4)(b).

(d) The Division shall then calculate a minimum payment under the federally mandated disproportionate share adjustment by dividing the amount of funds allocated pursuant to Section V (5) for payments under the federally mandated disproportionate share adjustment by the sum of the federally mandated disproportionate share ratios calculated pursuant to Section V (4)(c).

(e) The Division shall then multiply the minimum payment under the federally mandated Medicaid disproportionate share adjustment by the federally mandated Medicaid disproportionate share ratio established for each hospital pursuant to Section V (4)(a) and (b). Subject to the limits herein, the product of such multiplication is the payment under the federally mandated disproportionate share adjustment.

(5) Allocation of Funds. The total amount of funds allocated for payment to Non-acute Hospitals under the federally mandated Medicaid disproportionate share adjustment requirement is one hundred fifty thousand dollars annually. These amounts is paid by the Division of Medical Assistance, and distributed among the eligible hospitals as determined pursuant to Section V (4)(e).

VI. Extraordinary Disproportionate Share Adjustment for Psychiatric Hospitals.

The Division shall determine an extraordinary disproportionate share adjustment for all eligible Psychiatric Hospitals, using the data and methodology described in Section VI.

(1) Data Sources.

The Division shall use the DHCFP-403 report for the fiscal year two years prior to the fiscal year of the calculation of the disproportionate share adjustment to determine the cost, free care, charge, patient day, and net revenue amounts. If said

DHCFP-403 report is not available, the Division shall use the most recent available previous DHCFP-403 report to estimate these variables. If the specified data source is unavailable, then the Division shall determine and use the best alternative data source.

(2) Determination of Eligibility.

(a) In order to be eligible for the extraordinary disproportionate share payment adjustment, a Psychiatric Hospital must:

1. specialize in providing psychiatric/psychological care and treatment;
2. provide for special active treatment such as treatment of deafness, developmental disabilities, and the elderly;
3. accept all patients without regard to their ability to pay;
4. consist partly or wholly of locked wards;
5. meet requirements for the receipt of federal matching funds;
6. meet the low-income standard as set forth in Section VI (2)(b); and
7. meet the unreimbursed cost standard as set forth in Section VI (2)(c).

(b) Low-income standard.

1. For each Psychiatric Hospital, the Division shall calculate the hospital-specific low-income utilization rate as follows:

   a. The Division shall divide each hospital's net Medicaid revenue by its total gross patient service revenue.
   b. The Division shall divide each hospital's free care GPSR by its total GPSR.
   c. The total of these percentages shall equal the hospital's low-income utilization rate.

2. If the hospital-specific low-income utilization rate exceeds 45%, then the Psychiatric Hospital meets the low-income standard.

(c) Unreimbursed cost standard.

1. For each Psychiatric Hospital, the Division shall calculate the hospital-specific unreimbursed cost percentage as follows:

a. The Division shall calculate the costs of providing hospital services to Medicaid-eligible individuals and uninsured individuals, by multiplying total Hospital costs by the ratio of Medicaid Total Charges plus self pay Total Charges plus free care Total Charges to Total Charges.

b. The Division shall subtract the total of Medicaid payments (excluding any disproportionate share payments) plus self pay payments, from the costs determined in Section VI (2)(c)1.a., to determine the amount of unreimbursed costs.

c. The Division shall divide the amount of unreimbursed costs determined in Section VI (2)(c)1.b. by the costs determined in Section VI (2)(c)1.a. to determine the percentage of unreimbursed costs.

2. If the hospital-specific percentage of unreimbursed costs exceeds 50%, then the Psychiatric Hospital meets the unreimbursed cost standard.

(3) Determination of Payment. Subject to the limits herein, for each Psychiatric Hospital determined eligible for the extraordinary disproportionate share adjustment under Section VI (2), the payment amount is equal to the estimated rate year unreimbursed cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals, calculated as follows:

(a) First, determine the estimated rate year cost of providing hospital services to Medicaid-eligible individuals and uninsured individuals by determining the percentage of Medicaid, self-pay and Free Care Total Charges to Hospital Total Charges. Rate Year cost is determined by multiplying the FY 1996 Public Assistance RFR approved by DHCFP pursuant to 114.1 CMR 40.00 by inflation factor of 4.31%.

(b) Then, multiply this cost by the unreimbursed cost percentage determined pursuant to Section VI(2)(c)1.c.